Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,091.73 for date of service, 08/02/01.

   b. The request was received on 07/31/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92 (s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Example EOBs from other Carriers
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB-92(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/11/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/12/02. The response from the insurance carrier was received in the Division on 09/19/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 09/05/02

"We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES,** not professional fees. We feel that 21% paid on a right ankle arthrotomy is not fair or reasonable. We feel that (Carrier) should reimburse us more appropriately as $1118.00 does not cover our cost to perform this surgery….(Carrier) has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges. Also group insurance companies are allowing 100% of our billed charges. Since we are a small facility and have not done many of these types of surgeries, enclosed are only a few examples of bills for the same type of treatment of other patients and their insurance companies interpretation of fair and reasonable as shown by the amounts paid. Also, (Carrier) paid 100% of our charges for a surgery on 01/22/02, which is after this date of service in dispute and the amount was also more, where is the consistency of their methodology?"

2. Respondent: Letter dated 09/19/02

"THE CARRIER, IN DETERMINING WHAT CONSTITUTES A 'FAIR AND REASONABLE RATE' DID CONSIDER THE MEDICARE, PPO AND HMO PAYMENTS, AND REVIEWED THE COMMISSION'S OWN GUIDELINES FOR ACUTE CARE. ACUTE CARE GUIDELINES STATE THAT $1118.00 IS A VALID REIMBURSEMENT FOR A FULL DAY OF INPATIENT CARE, OR APPROXIMATELY 24 HOURS. BY DEFINITION, OUTPATIENT OR AMBULATORY SURGICAL SERVICES ARE THOSE THAT REQUIRE LESS THAN 90 MINUTES ANESTHESIA TIME AND LESS THAT [sic] FOUR HOURS OF RECOVERY. THIS MEANS THE PATIENT RECEIVES CARE FROM THE FACILITY FOR 1/4TH OF THE TIME OF BEING IN AN INPATIENT SETTING FOR A FULL DAY, AND THE FACILITY IS PAID THE TIME OF BEING IN AN INPATIENT SETTING FOR A FULL DAY, AND THE FACILITY IS PAID AT THE **EQUIVALENT OF** A ONE DAY INPATIENT STAY. **THE ACUTE CARE FEE GUIDELINES WERE USED AS A CONSIDERATION IN DETERMINING REIMBURSEMENT-HOWEVER, THIS DOES NOT MEAN THAT INPATIENT GUIDELINES WERE APPLIED TO THIS SERVICE.** THE CARRIER HAS CONSISTENTLY APPLIED THIS REIMBURSEMENT RATIONALE FOR ALL A.S.C. SERVICES PROVIDED IN 2001."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/02/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,209.73 for services rendered on the above date in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $1,118.00 for services rendered on the above date in dispute.

5. The Carrier's EOBs denied any additional reimbursement as "M – IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AT FAIR AND REASONABLE."

6. Per the Requestor's Table of Disputed Services, the amount in dispute is $4,091.73 for services rendered on the date of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…."

Section 413.011 (b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (I) (1-4) places certain requirements on the Carrier when reducing the billed amount to fair and reasonable. The burden is on the provider to show that the amount of reimbursement requested is fair and reasonable.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The requestor has provided some documentation to support their position that the amount billed is fair and reasonable. The Respondent has failed to comply with Rule 133.304(i). The Requestor's example EOBs reviewed reflected an average reimbursement of 85% of the billed amount. ($4,167.78 represents 85% of the billed amount - $1,118.00 Carrier reimbursement = $3,049.78). Therefore, based on the evidence available for review, the Requestor has established entitlement to additional reimbursement of **$3,049.78**.

The above Findings and Decision are hereby issued this 10th day of April 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$3,049.78** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 10th day of April 2003.

Carolyn Ollar
Supervisor - Medical Dispute Resolution Officer
Medical Review Division

CO/dt